APPENDIX F-1

TECHNICAL GUIDELINES FOR PAPER CLAIM PREPARATION FORM DPA 1443, PROVIDER INVOICE

Please follow these guidelines in the preparation of claims for imaging processing to assure the most efficient processing by the Department:

- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image.
- Use only one font style on a claim. Do not use bold print, italics, script, or any font that has connecting characters.
- Claims should be typed or computer-printed in capital letters. The character pitch must be 10-12 printed characters per inch, the size of most standard pica or elite typewriters. Handwritten entries should be avoided.
- All entries must be within the specified boxes. Do not write in the margins.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and provider signature.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not cut the strips, as it may alter the document size.
- Attachments containing a black border as a result of photocopying with the copier cover open cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- For attachments containing gray areas, either as a part of the original or as a result of photo-copying a colored background, print in the gray area is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to claims. Do not fold invoices or fasten attachments with staples.

Appendix F-1a is a copy of Form DPA 1443, Provider Invoice. Instructions for completion of the Provider Invoice follow in the order entries appear on the form. Mailing instructions follow the claim preparation instructions.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required	=	Entry always required.
Optional	=	Entry optional - In some cases failure to include an entry will result in certain assumptions by the Department and will preclude corrections of certain claiming errors by the Department.
Conditionally Required	=	Entries which are required only under certain circumstances. Conditions of the requirement are identified in the instruction text.
Not Required	=	Fields not applicable to the provision of podiatric services.

COMPLETION	ITEM EXPLANATION AND INSTRUCTIONS
Required	**1. Provider Name (First, Last)** - Enter the podiatrist's name exactly as it appears on the Provider Information Sheet.
Required	**2. Provider Number** - Enter the 12 digit provider key (number) exactly as it appears on the Provider Information Sheet. Do not use spaces or hyphens.
Conditionally Required	**3. Payee** - This entry is required when the podiatrist has more than one potential payee. Enter the one-digit code of the payee to whom payment is to be sent. Payees are coded numerically on the Provider Information Sheet.
	If no code is entered here, but the provider has designated more than one potential payee on the Provider Information Sheet, the claim will be rejected.
Not Required	4. Group - Leave blank.

Required	**5. Role** - Enter one of the following codes to define the relationship to the patient: A - Attending podiatrist B - Surgeon
Not Required	6. Acc/Inj (Accident/Injury) - Leave blank.
Optional	**7. Provider Reference** - Enter up to 10 numbers or letters used in the podiatrist's accounting system for identification. If this field is completed, the same data will appear on Form DPA 194-M-1, Remittance Advice, returned to the podiatrist.
Optional	**8. Provider Street** - Enter the street address of the podiatrist's primary office. If the address is entered, the Department will, where possible, correct claims suspended due to provider eligibility errors. If the address is not entered, the Department will not attempt corrections.
Conditionally Required	**9. Facility & City Where Service Rendered** - This entry is required when Place of Service Code in Field 28 (Service Sections) is other than A (provider's office) or K (patient's home).
Conditionally Required	**10. Prior Approval** - If prior approval was required for the procedure or item given, enter the prior approval number identified on the letter from the Department.
Optional	**11. Provider City** (State Zip) - Enter city, state and zip code of the podiatrist's primary office. See Item 8 above.
Not Required	12. Referring Practitioner Name - Leave blank.
Not Required	13. Ref. Prac. No. - Leave blank.
Required	**14. Recipient Name (First, MI, Last)** - Enter the patient's name exactly as it appears on the MediPlan Card, Temporary MediPlan Card or KidCare Card. Separate the components of the name (first, middle initial, last) in the proper sections of the name field.

Required	**15. Recipient No.** - Enter the nine digit number assigned to the participant as copied from the MediPlan Card, Temporary MediPlan or KidCare Card. Use no punctuation or spaces. Do **not** use the Case Identification Number. If the Temporary MediPlan Card does not contain the recipient number, enter the patient name and birth date on the Provider Invoice and attach a copy of the Temporary MediPlan Card to the Provider Invoice. The Department will review the claim and determine the correct recipient number. See "Mailing Instructions" in this Appendix when a copy of the Temporary MediPlan Card is attached.
Required	**16. Birthdate** - Enter the month, day and year of birth of the patient as shown on the MediPlan Card, Temporary MediPlan Card or KidCare Card. Use the six digit MMDDYY format. (January 28, 2001 is entered as 012801.)
Not Required	17. H Kids (Healthy Kids) - Leave blank.
Not Required	18. Fam Pla (Family Planning) - Leave blank.
Not Required	19. Cr Child (Crippled Children) - Leave blank.
Not Required	20. St/Ab (Sterilization/Abortion) - Leave blank.
Required	**21. Billing Date** - Enter the date the Provider Invoice was prepared. Use the six digit MMDDYY format. (January 28, 2001 is entered as 012801.)
Required	**22. Primary Diagnosis** - Enter the primary diagnosis which describes the condition primarily responsible for the patient's treatment.
Conditionally Required	**23. Prefix** - If the ICD 9-CM code identifying the diagnosis listed in item 22 has a prefix, enter the prefix.
Required	**24. Diag. Code** - Enter the appropriate ICD 9-CM code identifying the condition primarily responsible for the patient's treatment.
Conditionally Required	**25. Secondary Diagnosis** - Enter the diagnosis when treatment is the result of a condition different than the patient's primary condition.

Conditionally Required

26. Prefix - If the ICD 9-CM code identifying the diagnosis listed in item 25 has a prefix, enter the prefix.

Conditionally Required

27. Diag. Code - If a secondary diagnosis is identified in item 25, enter the appropriate ICD 9-CM code identifying that diagnosis.

Required

28. Service Sections: Complete one service section for each item or service provided to the patient.

Conditionally Required

Procedure Description/Drug Name - Enter the appropriate description of the service provided or item dispensed.

Required

Proc. Code/Drug Item No. - Enter the appropriate five digit procedure code as specified in the fee schedules.

Conditionally Required

Delete - When an error has been made that cannot be corrected enter an "X" to delete the entire service section. Only "X" will be recognized as a valid character; all others will be ignored.

Required

Date of Service - Enter the date the service was performed. Use the six digit MMDDYY format. (January 28, 2001 is entered as 012801.)

Required

Cat. Serv. - Enter the appropriate Category of Service code.
04 - Podiatric Services

Required

Place of Serv. - Enter the one letter Place of Service code from the following list:

Code:	**Place of Service**:
A	Provider's Office
B	Hospital - Inpatient
C	Hospital - Outpatient
H	Long Term Care Facility
I	Sheltered Care Facility
K	Patient’s Home

Conditionally Required

Units/Quantity - Enter the appropriate number if drugs have been dispensed. Enter the number 2 if bilateral procedures were performed.

Not Required

Modifying Units - Leave blank.

Conditionally Required

TPL Code - If the patient's MediPlan or KidCare Card contains a TPL code, the code is to be entered in this field. If there is no TPL resource shown on the card, no entry is required.

Conditionally Required

Status - If a TPL code is shown in the previous item, a two digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL code is 000 or blank.

The TPL Status Codes are:

01 - TPL Adjudicated - total payment shown: TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received **must** be entered in the TPL amount box.

02 - TPL Adjudicated - patient not covered: TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided.

03 - TPL Adjudicated - services not covered: TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered.

04 - TPL Adjudicated - spenddown met: TPL status code 04 is to be entered when the patient's Form DPA 2432, Split Billing Transmittal, shows $0.00 liability.

When the date of service is the same as the "Spenddown Met" date on the DPA 2432, Split Billing Transmittal, attach the DPA 2432 to the invoice. The split bill transmittal supplies the information necessary to complete the TPL fields.

If Form DPA 2432, Split Billing Transmittal, shows a participant liability greater than $0.00 the invoice should be coded as follows:

TPL Code	906
TPL Status	01
TPL Amount	The actual participant liability as shown on form DPA 2432.
TPL Date	The issuance date on the bottom right corner of the DPA 2432. This is in the six digit MMDDYY format.

If Form DPA 2432, Split Billing Transmittal, shows a recipient liability of $0.00 the invoice should be coded as follows:

TPL Code	906
TPL Status	04
TPL Amount	0 00
TPL Date	The issuance date on the bottom right corner of the DPA 2432. This is in the six digit MMDDYY format.

05 - Patient not covered: TPL Status Code 05 is to be entered when a participant informs the provider that the third party resource identified on the MediPlan Card is not in force.

06 - Services not covered: TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided.

07 - Third Party Adjudication Pending: TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed and reasonable follow-up efforts to obtain payment have failed.

10 - Deductible not met: TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.

Conditionally Required

TPL Amount - Enter the amount of payment received from the third party health resource. A dollar amount entry is required if TPL Status Code 01 was entered in the "Status" box. If there is no TPL code, no entry is required.

Conditionally Required

Adjudication Date - A TPL date is required when any status code is shown in Item 28J. Use the date specified below for the applicable code:

Code	Date to be entered
01	Third Party Adjudication Date
02	Third Party Adjudication Date
03	Third Party Adjudication Date
04	Date from the DPA 2432
05	Date of Service
06	Date of Service
07	Date of Service
10	Third Party Adjudication Date

Required

Provider Charge - Enter the total charge for the service, not deducting any TPL.

Not Required

Repeat - Leave blank.

Not Required

29. Optical Materials Only - Leave blank.

Charges and Deductions Section (**Unlabeled**) - The information field in the lower right of the Provider Invoice is to be used: 1) to identify additional third party resources in instances where the patient has access to two or more resources and 2) to calculate total and net charges.

If a second third party resource was identified for one or more of the services billed in service sections 1 through 7 of the Provider Invoice, complete the TPL fields in accordance with the following instructions:

Conditionally Required	**Sect. #** - If more than one third party made a payment for a particular service, enter the service section number (1 through 7) in which that service is reported. If a third party resource made a single payment for several services and did not specify the amount applicable to each, enter the number 0 (zero) in this field. When 0 is entered, the third party payment shown in section 30 will be applied to the total of all service sections on the Provider Invoice.
Conditionally Required	**TPL Code** - Enter the appropriate TPL Resource Code referencing the source of payment (Refer to Chapter 100 General Appendix 9). If the TPL Resource Codes are not appropriate, enter 999 and enter the name of the payment source in the Uncoded TPL Name field.
Conditionally Required	**Status** - Enter the appropriate TPL Status Code. See the Status field in Item 28 above for correct coding of this field.
Conditionally Required	**TPL Amount** - Enter the amount of payment received from the third party resource.
Optional	**Adjudication Date** - Enter the date the claim was adjudicated by the third party resource. (See the Adjudication Date field in Item 28 above for correct coding of this field.)
Conditionally Required	**Uncoded TPL Name** - Enter the name of the third party health resource. The name must be entered if TPL code 999 is used.

Claim Summary Fields: The three claim summary fields must be completed on all Provider Invoices. These fields are Total Charge, Total Deductions and Net Charge. They are located at the bottom far right of the form.

Required	**Total Charge** - Enter the sum of all charges submitted on the Provider Invoice in service section 1 through 7.
Required	**Total Deductions** - Enter the sum of all payments received from other sources. If no payment was received, enter three zeroes (000).

Required	**Net Charge** - Enter the difference between Total Charge and Total Deductions.
Required	**31. # Sects** - Enter the total number of service sections completed correctly in the top part of the form. This entry must be at least one and no more than seven. Do not count any sections which were deleted because of errors.
Not Required	32. Original DCN - leave blank.
Not Required	33. Original Voucher Number - leave blank.
Required	**Provider Certification, Signature and Date** - After reading the certification statement, the provider must sign the completed form. The signature must be handwritten in black or dark blue ink. A stamped or facsimile signature is not acceptable. Unsigned Provider Invoices will not be accepted by the Department and will be returned to the provider when possible. The signature date is to be entered.

MAILING INSTRUCTIONS

The Provider Invoice is available as a single sheet or multi page continuous feed form. Single sheet billing forms are intended for use only in laser printers. Multi page continuous feed forms are intended for use in either typewriters or impact printers.

The pin-feed guide strip must be detached from the sides of continuous feed forms.

Routine claims are to be mailed to the Department in a pre-addressed mailing envelopes, Form DPA 1444, Provider Invoice Envelope, provided by the Department.

Non-routine claims are to be mailed to the Department in pre-addressed mailing envelope, Form DPA 2248, Special Handling Envelope, which is provided by the Department for this purpose. A non-routine claim is one to which one or more of the following documents are attached:

- Form DPA 1411, Temporary MediPlan Card.
- An operative report or hospital discharge summary.
- Any other document.

APPENDIX F-1a
Reduced Facsimile of Form DPA 1443, Provider Invoice

PROVIDER INVOICE
ILLINOIS DEPARTMENT OF PUBLIC AID

IDPA USE ONLY

ELITE PICA

TYPEWRITER ALIGNMENT
<----------**USE CAPITAL LETTERS ONLY**---------->

ELITE PICA

NNN

1. PROVIDER NAME (First, Last) | 2. Provider Number | 3. Payee | 4. Group | 5. Role | 6. Acc/Inj | 7. Provider Reference

8. Provider Street | 9. Facility and City Where Service Rendered | 10. Prior Approval

11. Provider City | 12. Referring Practitioner Name (First, Last) | 13. Ref. Prac. No.

14. Recipient Name, (First, MI, Last) | 15. Recipient Number | 16. Birthdate | 17. H Kids | 18.Fam Plar | 19 Cr Child | 20 St/Ab | 21. Billing Date

22. Primary Diagnosis | 23. Prefix | 24. Diag. Code

25. Secondary Diagnosis | 26. Prefix | 27. Diag. Code

28. Service Sections

1
Procedure Description / Drug Name, Form and Strength or Size | Proc. Code/Drug Item No. | Delete

Date of Service | Cat. Serv. | Place of Serv | Units/Quanty | Modifying Units | TPL Code | Status | $ TPL Amount | Adjudication Date | $ Provider Charge

2
Repeat | Procedure Description / Drug Name, Form and Strength or Size | Proc. Code/Drug Item No. | Delete

Date of Service | Cat. Serv. | Place of Serv | Units/Quanty | Modifying Units | TPL Code | Status | $ TPL Amount | Adjudication Date | $ Provider Charge

Note: Center section of form has been removed to enlarge detail. The actual form has 7 Service Sections.

7
Repeat | Procedure Description / Drug Name, Form and Strength or Size | Proc. Code/Drug Item No. | Delete

Date of Service | Cat. Serv. | Place of Serv | Units/Quanty | Modifying Units | TPL Code | Status | $ TPL Amount | Adjudication Date | $ Provider Charge

29. OPTICAL MATERIALS ONLY

Sec # | TPL Code | Status | $ TPL Amount | Adjudicaton Date | $ Total Charges

Sec # | TPL Code | Status | $ TPL Amount | Adjudication Date | $ Total Deductions

Sec # | TPL Code | Status | $ TPL Amount | Adjudication Date | $ Net Charges

31. # Sects | 32. Original DCN | 33. Orig Voucher # | Uncoded TPL Name

My signature certifies that: all entries on this claim are true, accurate and complete; the State's Medical Assistance Program pricing limits will be accepted as payment in full; any payments received from this patient or any other third party will be properly credited or paid to the Illinioins Department of Public Aid; records necessary to fully disclose the nature and extent of services provided are maintained and will be made available upon request of State and Federal officials responsible for the various aspects of the State's Medical Assistance Program , as provided under Title XIX of the Social Security Act and applicable State statutes; I provided or directly supervised all services for which a charge appears; I understand

payment is made from State and Federal funds and that any falsification or concealment of material fact may lead to appropriate legal action; in compliance with the Civil Rights Act of 1964, services were provided without discrimination on the grounds of race, color or national origin; and handicapped persons are afforded the rights and consideration specified in Section 504 of the Rehabilitation Act of 1973 and Part 84 of the Code of Federal Regulations.

Signature | Date

DPA 1443 (R-1-91) Completion mandatory, Ill. Rev. Stat., Ch. 23, P.A. Code, penalty non-payment. Form Approved by the Forms Management Center. IL478-1210

APPENDIX F-1b

PREPARATION AND MAILING INSTRUCTIONS FOR MEDICARE/MEDICAID COMBINATION CLAIMS

Chapter 100, Topic 120.1 provides general guidance for claim submittal and payment when a patient is covered by both Medicare and Medicaid. These are generally referred to as combination claims. This Appendix provides detailed instructions for coding Medicare claims to facilitate proper consideration for payment of co-insurance and deductibles by the Department.

Coding and Submission of Claims to the Medicare Carrier or DMERC

Charges for services provided to covered participants who are also eligible for Medicare benefits must be submitted to the Medicare Carrier on Form HCFA 1500. The words "Illinois Department of Public Aid" or "IDPA" and the patient's nine digit Recipient Identification Number are to be entered in Field 9a of the Form HCFA 1500. Field 27 must be marked "Yes", indicating the provider will accept assignment.

In many instances, this entry will cause the claim to "cross over", that is, the claim will be forwarded to the Department by the Medicare Carrier automatically, without any further action by the provider. This is referred to as a crossover claim. When a claim crosses over, the Explanation of Medicare Benefits (EOMB) will contain a message or code indicating that the claim has been sent to the Department. The claim will appear later on a Department Remittance Advice after it has been adjudicated.

Submission of Claims That Do Not Automatically Cross Over

For consideration of payment of the coinsurance and deductible, the provider must submit the claim directly to the Department when:

- payment is made by the Medicare Carrier but the EOMB does not show that the claim has been crossed over, or
- when more than 90 days has elapsed since the Medicare payment but the claim has not appeared on a Department Remittance Advice.

Submit a copy of Form HCFA 1500 with a copy of the Medicare EOMB or the Medicare payment voucher.

Prior to submitting the claim to the Department, the following additional information must be entered on Form HCFA 1500:

- the provider name in Field 33 exactly as it appears on the Provider Information Sheet,

- the provider's Provider Number in the lower right corner of Field 33, and
- the one digit provider payee code (if the provider has multiple payees listed on the Provider Information Sheet) in Field 33 immediately following the Provider Name.

If the HCFA 1500 submitted to Medicare lists services of two or more practitioners, a separate claim and EOMB is required for each. In addition, the services provided by each practitioner must be identified.

The disposition of the claim will be reported on the Department's Remittance Advice.

Provider Action on Services Totally Rejected by Medicare

The Department's liability for payment is generally based on Medicare's determination as to medical necessity and utilization limits. Before submitting a denied claim to the Department, the provider should review the reason for Medicare's denial to determine if submittal of the claim is indicated. In general, the provider should submit a claim to the Department for payment consideration only when the reason for Medicare's denial of payment is either:

- the patient was not eligible for Medicare benefits or
- the service is not covered as a Medicare benefit.

In such instances, the Department is to be billed only after final adjudication of the claims by the Medicare Carrier. If the provider has requested a reconsideration of Medicare's denial, the Department is not to be billed until after Medicare's reconsideration decision.

Claims which have been denied by Medicare for which the provider is seeking payment must be submitted on a Form DPA 1443 with a copy of the EOMB attached. If Medicare reconsideration was requested and denied, a copy of the reconsideration decision and any correspondence should also be attached.

APPENDIX F-2

PREPARATION AND MAILING INSTRUCTIONS FOR FORM DPA 1409, PRIOR APPROVAL REQUEST

Form DPA 1409, Prior Approval Request, is to be submitted by the podiatrist for certain specified services in order for the services to qualify for reimbursement. Services and items requiring prior approval are identified in this handbook.

Form DPA 1409 is a multi-part form. Appendix F-2a contains an example of the form.

INSTRUCTIONS FOR COMPLETION

The form is to be typewritten or legibly hand printed. Instructions for completion follow in the order entries appear on the form. Mailing instructions follow the form preparation instructions.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required	=	Entry always required.
Conditionally Required	=	Entries which are required only under certain circumstances. Conditions of the requirement are identified in the instruction text.
Not Required	=	Fields not applicable; leave blank.

COMPLETION		ITEM EXPLANATION AND INSTRUCTIONS
		Document Control Number - leave blank.
Not Required	1.	Trans Code (Transaction Code) - Leave blank.
Not Required	2.	Prior Approval Number - Leave blank.
Required	**3.**	**Case Name** - Enter the case name from the participant's MediPlan Card, Temporary MediPlan Card or KidCare Card. The case name appears on the front of the card in conjunction with the mailing address.

Required **4.** **Recipient Name** - Enter the name of the participant for whom the service or item is requested.

Required **5.** **Recipient Number** - Enter the nine digit recipient number assigned to the participant for whom the service or item is requested. This number is found to the right of the participant's name on the back of the MediPlan or KidCare Card.

Required **6.** **Birth date** - Enter the participant's birth date. This is a six-digit field. Entry must be in six digit MMDDYY format. (January 28, 2001 is entered as 012801.)

Conditionally Required **7.** **Inst Set (Institutional Setting)** - An entry in this field is required only when the participant resides in a long term care facility.

Enter one of the following codes to identify the arrangement:
H = Long-Term Care Facility
I = Sheltered Care Facility

Required **8.** **Case Identification Number** - Enter the Case Identification Number from the participant's MediPlan Card, Temporary MediPlan Card or KidCare Card. This number is found on the primary portion (front) of the card immediately above the case name and mailing address.

Required **9.** **Recipient Street Address** - Enter the participant's current street address. The Department will use this information to mail the participant the "Notice of Decision on Request for Medical Service/Item".

Conditionally Required **10.** **Facility Name** - An entry in this field is required only when an entry appears in Item 7 above.

Required **11.** **Recipient City** - Refer to Item 9 above.

Conditionally Required **12.** **Facility City** - An entry in this field is required only when an entry appears in Items 7 and 10.

Required **13.** **Requesting Provider Name** - Enter the name of the requesting provider.

Required **14.** **Requesting Prov No** - Enter the requesting provider's Provider Number exactly as shown on the Provider Information Sheet.

Required **15.** **Provider Street** - Enter the provider's address. This information will be used to return a copy of the processed (approved/denied) request.

Required **16.** **Provider Telephone** - Enter the telephone number of the provider's office. This information is helpful in instances when the Department needs additional information in order to act upon the request.

Required **17.** **Provider City, State, Zip** - Enter the provider's city, state and zip.

Not Required 18 - 26 Leave blank.

27. **Service Sections** - The form provides space to request a maximum of three services/items. When more than three services are requested, a second form must be completed. Instructions for completion of entry fields contained within a service section follow:

Required **Req. Proc. Code (Requested Procedure Code)** - Enter the five-digit procedure code which identifies the procedure for which approval is requested.

Required **Req Qty (Requested Quantity)** - Enter the number of items or the number of times the service is to be performed.

Required **Prov Charge (Provider Charge)** - Enter the provider's charge for the service(s).

Required **Cat. Serv. (Category of Service)** - Enter the appropriate Category of Service code.
04 - Podiatric Services

Required **Description** - Briefly describe the services, items or materials to be provided. If additional space is needed, provide the information on letterhead paper, identifying the patient by name and Recipient Identification Number.

Required **28.** **Medical Necessity** - The provider is to enter a statement as to the need for the service(s) requested. In addition to a narrative explanation, a diagnosis should be provided. If additional space is

needed, provide the information on letterhead paper, identifying the patient name and Recipient Identification Number.

Required **29.** **Supplying Provider Signature** - The form is to be signed in ink by the individual who is to provide the service.

Required **31.** **Request Date** - Enter the date the form is signed.

MAILING INSTRUCTIONS

Before mailing, carefully review the request for completeness and accuracy. The top, signed copy of the request is to be mailed to:

Illinois Department of Public Aid
Bureau of Comprehensive Health Services
Post Office Box 19105
Springfield, Illinois 62794-9105

The remaining copies may be retained in the provider's records.

A notification of approval or denial of the service(s) will be mailed to the provider. The service is not to be provided until the approval notification is received.

APPENDIX F-2a
Reduced Facsimile of Form DPA 1409, Prior Approval Request

PRIOR APPROVAL REQUEST

ILLINOIS DEPARTMENT OF PUBLIC AID

Document Control Number

"Completion Mandatory, Ill.Rev.Stat., PA Code, penalty non-payment. Form Approved

CCC

1.Trans Code | 2.Prior Approval Number | 3.Case Name

4.Recipient Name (First, MI, Last) | 5.Recipient Number | 6.Birth date | 7.Inst.Set | 8.Case Number

9.Recipient Street | 10.Facility Name

11.Recipient City | State | Zip | 12.Facility City

13.Requesting Provider Name | 14.Requesting Prov.No.

15.Provider Street | 16.Provider Telephone ( )

17.Provider City | State | Zip

18.Supplying Provider Name | 19.Supply Prov.No.

20.Provider Street | 21.Provider Telephone ( )

22.Provider City | State | Zip

23.Aprv.Authority | 24.Disp.Date | 25. Approving Authority Signature | 26.Receipt Date

27.SERVICE SECTIONS

1	Req.Proc.Code	Req.Qty.	Prov.Charge	Cat.Serv	Description
DISP STATUS	Aprv.Proc.Code	Aprv.Qty.	Unit Amount		
0=Denied 1=Aprv.	Total Amount	Begin Date	End Date		Reason For Denial
2	Req.Proc.Code	Req.Qty.	Prov.Charge	Cat.Serv	Description
DISP STATUS	Aprv.Proc.Code	Aprv.Qty.	Unit Amount		
0=Denied 1=Aprv.	Total Amount	Begin Date	End Date		Reason For Denial
3	Req.Proc.Code	Req.Qty.	Prov.Charge	Cat.Serv	Description
DISP STATU	Aprv.Proc.Code	Aprv.Qty.	Unit Amount		
0=Denied 1=Aprv.	Total Amount	Begin Date	End Date		Reason For Denial

28. Medical Necessity

This is to certify that the information above is true, accurate and complete.

29. Supplying Provider Signature | 30.Request Date

DPA 1409 (R-1-92) IL478-1100

APPENDIX F-3
Reduced Facsimile of Request for Approval for Podiatry Services

Illinois Department of Public Aid

REQUEST FOR APPROVAL FOR PODIATRY SERVICES

Patient Name _____ Recipient Number _____

Address (Street) _____ (City) _____

1. Diagnosis: _____

2. Past Treatment Provided For Presenting Condition: _____

3. Past Surgery (Include Type and Date): _____

4. Orthomechanical Device (Include Procedure code and Date): _____

5. Description of Item or Service for Which Approval is Being Requested: _____

6. Medical Necessity/Prognosis: _____

Completion mandatory, Ill. Rev. Stat., Ch.23, P.A. Code, penalty non-payment. Form approved by Forms Management Center.

Provider Name _____ Date _____

DPA 314A (R-5-2000) IL478-1060

APPENDIX F-4

EXPLANATION OF INFORMATION ON PROVIDER INFORMATION SHEET

The Provider Information Sheet is produced when a provider is enrolled in the Department's Medical Programs. It will also be generated when there is a change or update to the provider record. This sheet will then be mailed to the provider and will serve as a record of all the data that appears on the Provider Data Base.

If, after review, the provider notes that the Provider Information Sheet does not reflect accurate data, the provider is to line out the incorrect information, note the correct information, sign the document and return it to the Provider Participation Unit in Springfield, Illinois. (See Topic F-201.4 for instructions.) If all the information noted on the sheet is correct, the provider is to keep the document and reference it when completing any Department forms.

The following information will appear on the Provider Information Sheet. A sample of a Provider Information Sheet is attached as Appendix F-4a. The item or area numbers that correspond to the explanations below appear in small circles ◯ on the sample form.

	FIELD	EXPLANATION
1	**PROVIDER KEY**	This number uniquely identifies the provider and is to be used as the provider number when billing charges to the Department.
2	**PROVIDER NAME AND LOCATION**	This area contains the **NAME AND ADDRESS** of the provider as carried in the Department's records. The three-digit **COUNTY** code identifies the county in which the provider maintains his primary office location. It is also used to identify a state if the provider's primary office location is outside of Illinois. The **TELEPHONE NUMBER** is the primary telephone number of the provider's primary office.
3	**ENROLLMENT SPECIFICS**	This area contains basic information reflecting the manner in which the provider is enrolled with the Department. **PROVIDER TYPE** is a three-digit code and corresponding narrative which indicates the provider's classification.

ORGANIZATION TYPE is a two-digit code and corresponding narrative indicating the legal structure of the environment in which the provider primarily performs services. The possible codes are:

01 = Individual Practice
02 = Partnership
03 = Corporation

ENROLLMENT STATUS is a one-digit code and corresponding narrative which indicates whether or not the provider is currently an active participant in the Department's Medical Programs. The possible codes are:

B = Active
I = Inactive
N = Non Participating

Disregard the term NOCST if it appears in this item.

Immediately following the enrollment status indicator are the **BEGIN** date indicating when the provider was most recently enrolled in the Department's Medical Programs and the **END** date indicating the end of the provider's most current enrollment period. If the provider is still actively enrolled, the word "ACTIVE" will appear in the **END** date field.

EXCEPTION INDICATOR may contain a one-digit code and corresponding narrative indicating that the provider's claims will be reviewed manually prior to payment. The possible codes are:

A = Exception Requested By Audits
C = Citation to Discover Assets
G = Garnishment
S = Exception Requested By Provider Participation Unit
T = Tax Levy

If this item is blank, the provider has no exception.

Immediately following the **EXCEPTION INDICATOR** is the **BEGIN** date indicating the first date when the provider's claims were to be manually reviewed and the **END** date indicating the last date the provider's claims were to be manually reviewed. If the provider has no exception, the date fields will be blank.

AGR (Agreement) indicates whether the provider has a form DPA 1413, Provider Agreement, on file and the provider is eligible to submit claims electronically. Possible entries are YES or NO.

4 **CERTIFICATION/ LICENSE NUMBER**

This is a unique number identifying the license issued by a state agency authorizing a provider to practice or conduct business. This entry is followed by the **ENDING** date indicating when the license will expire.

5 **S.S.#**

This is the provider's social security or FEIN number.

6 **SPECIALTY AND CATEGORIES OF SERVICE**

This area identifies special licensure information and the types of services a provider is enrolled to provide.

SPECIALTY CODE is not applicable to podiatrists.

ELIGIBILITY CATEGORY OF SERVICE contains a three-digit code and corresponding narrative indicating the type of service a provider is authorized to render to patients covered under the Department's Medical Programs. The proper code is:

004 = Podiatric Services

This entry is followed by the date that the provider was approved to render podiatric services.

7 **PAYEE INFORMATION**

This area records the name and address of any persons or entities authorized to receive payments on behalf of the provider. Each potential payee is assigned a single digit **PAYEE CODE**, which is to be used on the claim form to designate the payee to whom the warrant is to be paid.

If no payee number is designated on a claim form, but multiple payees are shown on the Provider Information Sheet, the claim will be rejected.

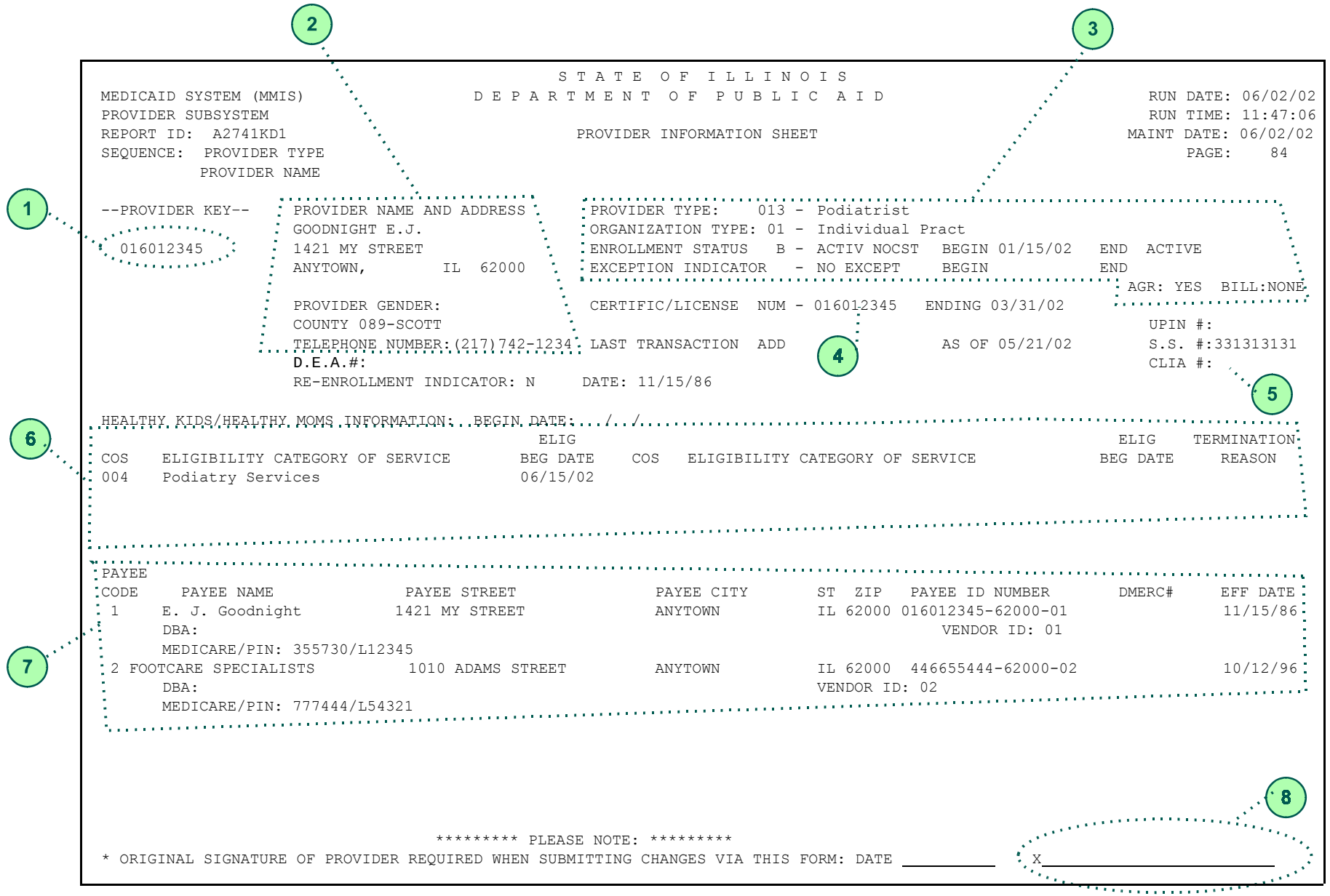
PAYEE ID NUMBER is a sixteen-digit identification number assigned to each payee to whom warrants may be issued. A portion of this number is used for tax reporting purposes, therefore no payments can be made to a payee unless the number is on file. Immediately following this number is the effective date when payment may be made to each payee on behalf of the provider.

The **MEDICARE/PIN** or the **DMERC #** is the number assigned to the payee by the Medicare Carrier to cross-over Medicare billable services. The **PIN** is the number assigned by Medicare to a provider within a group practice, if applicable.

8 **SIGNATURE**

The provider is required to affix an original signature when submitting changes to the Department of Public Aid.

APPENDIX F-4a
Reduced Facsimile of Provider Information Sheet



STATE OF ILLINOIS
MEDICAID SYSTEM (MMIS) DEPARTMENT OF PUBLIC AID RUN DATE: 06/02/02
PROVIDER SUBSYSTEM RUN TIME: 11:47:06
REPORT ID: A2741KD1 PROVIDER INFORMATION SHEET MAINT DATE: 06/02/02
SEQUENCE: PROVIDER TYPE PAGE: 84
PROVIDER NAME

--PROVIDER KEY--
016012345

PROVIDER NAME AND ADDRESS
GOODNIGHT E.J.
1421 MY STREET
ANYTOWN, IL 62000

PROVIDER GENDER:
COUNTY 089-SCOTT
TELEPHONE NUMBER:(217)742-1234
D.E.A.#:
RE-ENROLLMENT INDICATOR: N DATE: 11/15/86

PROVIDER TYPE: 013 - Podiatrist
ORGANIZATION TYPE: 01 - Individual Pract
ENROLLMENT STATUS B - ACTIV NOCST BEGIN 01/15/02 END ACTIVE
EXCEPTION INDICATOR - NO EXCEPT BEGIN END
AGR: YES BILL:NONE

CERTIFIC/LICENSE NUM - 016012345 ENDING 03/31/02
LAST TRANSACTION ADD AS OF 05/21/02
UPIN #:
S.S. #:331313131
CLIA #:

HEALTHY KIDS/HEALTHY MOMS INFORMATION: BEGIN DATE: / /

COS	ELIGIBILITY CATEGORY OF SERVICE	ELIG BEG DATE	COS	ELIGIBILITY CATEGORY OF SERVICE	ELIG BEG DATE	TERMINATION REASON
004	Podiatry Services	06/15/02				

PAYEE CODE	PAYEE NAME	PAYEE STREET	PAYEE CITY	ST ZIP	PAYEE ID NUMBER	DMERC#	EFF DATE
1	E. J. Goodnight	1421 MY STREET	ANYTOWN	IL 62000	016012345-62000-01		11/15/86
	DBA:				VENDOR ID: 01		
	MEDICARE/PIN: 355730/L12345						
2	FOOTCARE SPECIALISTS	1010 ADAMS STREET	ANYTOWN	IL 62000	446655444-62000-02		10/12/96
	DBA:				VENDOR ID: 02		
	MEDICARE/PIN: 777444/L54321						

********* PLEASE NOTE: *********
* ORIGINAL SIGNATURE OF PROVIDER REQUIRED WHEN SUBMITTING CHANGES VIA THIS FORM: DATE _____ X_____